Administrative Systems and Management

The information from the green books that NGOs use to check how drugs are prescribed, is not reliable, and the green books do not deal with the major problem - the healthworker's ability to make a correct diagnosis. The need to use green books for checking healthworkers, will decrease because the number of healthworkers working independently is decreasing.

I believe the use of "green books" should be stopped as well as the work of making statistics from them.

The need for establishment of good administrative routines, and recordkeeping at the larger clinics and hospital is striking. The exception was at Rokha where I was impressed by the records that have been developed by Dr Walid. And only in Rokha was there a clear attempt to divide the tasks between the staff members and assign responsibilities to each.

Practical Monitoring Aspects

Passing the border between Pakistan and Afghanistan is a major problem and a major concern of most foreign monitors. I recommend that ACBAR discusses the situation with the Pakistan authorities. Hopefully the Pakistan authorities can facilitate border crossings. This has been done occasionally (MSF-France).

In regard to monitoring many of the CMC member organizations have their own Afghan monitors that do the basic work of checking on persons and places. In Nahrin I met AVICEN monitors, MSH monitors and an IMC-monitor! CMC should review the contributions that a foreign monitor can make to better integrate the CMC monitoring with member group monitoring in order to reduce overlap and unnecessary data collection.

TABLE OF HEALTH CARE SERVICES

	ABDOMINAL SURGERY	AMPUTATION	WOUND CARE	CEASAREAN SECTION	GYNE-EXAM/ DELIVERY	FEMALE WARD	WORKING X-RAY	WORKING LABORATORY	GRADUATE DOCTORS	DENTAL SERVICES
YOKH HOSPITAL	(X)	X	X						1	
TALOQAN HOSPITAL	X	X	X		X	X			4	(X)
KHANABAD HOSPITAL		X	X			?			1	
ROKHA HOSPITAL	X	X	X			X		X	10	X
PANJSHIR "CAVE HOSPITAL"	X	X	X							
FARKHAR CLINIC		(X)	X						0	(X)
NAHRIN CLINIC		(X)	X		X		X	(M)	0	(X)

(X) = PARTIAL SERVICES

(M) = MALARIA EXAMS ONLY

? = NOT CLEAR AT VISIT

4. A NARRATIVE OF THE JOURNEY

(For a day-by-day journey date listing, please see Appendix 11.1)

Originally CMC mission # 5 was planned for Badakshan province. Two monitors were contracted, Greg Chernish (Canadian M.D.) and Annika Janson (Swedish M.D.).

Twelve hours before the team was to depart from Peshawar to Chitral, Greg Chernish was found to be very sick and unable to go. Annika Janson left as planned the next morning, together with the translator Sayed Habib Shah. The CMC-team left with two other teams: one Swedish Committee - IFAD team aiming for the Keshim valley, and another Swedish Committee team aiming for the North-East. An Afghan guide was also hired.

The pre-trip plans called for the three teams to go together to Keshim in western Badakshan, and then split up with the SCA-IFAD team staying in Keshim, the SCA-team heading west towards Baghlan, and the CMC team working its way from Keshim to Jurm. For me, it was however regarded unacceptable to travel alone with a male translator. Therefore the CMC-team and the SCA-team travelled together, trying to see both Badakshan and the other Northern provinces.

The teams left Peshawar Aug 20th, and lodged with friends from Freedom Medicine in Chitral so as not to be seen by the Pakistan authorities. The crossing of the border had been well planned in advance, and the teams passed the Pakistan check-posts the next afternoon. It was uncomplicated but uncomfortable, with the four expatriates hiding in a minimal space in a pick-up load of medicines.

The actual border is about two hours' ride from where the road ends and it was crossed the next morning. Horses had been rented in Garam Chesma in Pakistan, where they were plentiful. Four days were spent on horse-back to reach Warsaj in Takhar province, going by way of Topkhana (JOG: Tahana-i-Bandar) and entering Takhar via the pass to Piw.

The area is partly (around Topkhana) heavily mined, and until we reached Koran and Skazar, we saw few indications of civilian life. In Koran (once a location of a government airport) and Skazar wheat was being harvested and we saw dozens of farm animals. The weeds were plentiful, but apart from the prior government holdings, the level of destruction was low.

When we passed the entry to the Jurm valley that runs north from Skazar, heavy fighting was reported. It seemed that the commander of Jurm, Said Najmuddin, Jamiat-e-Islami (JIA), had attacked the government in Zebak. In the meantime Hezb-Islami attacked the JIA holdings in Barak north of Jurm, and the government replied with bombardment of Zebak (the planes said to have taken off from USSR). There is an additional old tension between Said Najmuddin and Abdul Basir, JIA commander of the upper Yaftal valley north of Barak. Said Najmuddin left Zebak and went back to defend Barak. We chose to go to Keshim by the way of Farkhar.

The Piw-valley is intact and here we saw rural life with women and children helping with the harvest in the fields. According to a local commander the valley had only been bombed once in ten years. In Piw we also saw commander Ahmad Shah Massoud and had a meeting with him. With Afghan hospitality he offered us lunch and a ride to Khanaqa (main village of Warsaj) in his private Russian jeep.

In the village Askin in Warsaj, we saw a Shura-e-Nizar health clinic under construction. (The previous SCA-clinic is closed down). We went by truck to Yokh hospital south of Farkhar, and spent a night at the clinic in Farkhar. In Farkhar we hired a private car to take us to the province capital Taloqan, and on the way we passed the place where the July incident between Sayed Jamal (HIA) and JIA took place, in which some 30 Jamiat men were killed.

The area along the road between Farkhar and Taloqan is heavily destroyed, with skeletons of military vehicles and metallic scrap everywhere. The rest of the Farkhar valley seems to be rather unaffected by the war.

We arrived in Taloqan at the time of the starting of the trial of the captured Sayed Jamal. It was also time for HIA-leader Gulbuddin Hekmatyar to refuse to participate further in the work of the interim government, and despite his withdrawal as Foreign Minister, he stated on radio broadcast that no foreigners could visit Afghanistan without his personal authorization.

Taloqan is a thriving city, the largest one we saw. It was liberated about a year ago. The reconstruction work has been disturbed by the unclear political situation, but is now well underway. Commander Massoud wants to make Taloqan the prime example of a city administered by the "government" of Shura-e-Nizar. The area around Taloqan and Khanabad before the war was an important agricultural area in Afghanistan, exporting food to other parts of the country.

I visited the Taloqan hospital, and carried out prevalence studies there (see Section 6 "The Prevalence of Disease").

The members of the SCA-IFAD team left for Keshim and came back a day and a half later. They had witnessed heavy fighting with JIA holding the city and its southern surroundings, and HIA holding the northern part of the valley and the road to Faizabad. To us, official JIA persons in Taloqan said it would take at least 6 weeks to "clear the situation out".

Since we estimated that we would be unable to travel in the valleys around Keshim, and because no one really wanted to take foreigners into the area, we decided to leave Badakshan and go east to Khanabad. For me this meant that I could not go to the area which I had prepared to monitor, but instead would check an area where I carried little information about existing health facilities.

We went by car to Khanabad and spent a few days there with Ittehad commander Amir Mohammed. Khanabad was liberated a year ago and has been largely destroyed. I visited Khanabad hospital run by four parties cooperating in the Khanabad Shura, and carried out prevalence studies there.

We went back to Taloqan where we had a second meeting with Commander Massoud. He asked us to report the need for assistance to Taloqan City to all cross-border agencies. A few bombs fell over Taloqan when we were sitting with the General Amir, adding a lively atmosphere to the situation. These airplanes, too, were said to have flown in from the USSR.

We then spent three days, often walking, skirting around HIA-villages to reach Nahrin, normally located "six hours' drive" from Taloqan. We were accidentally shot at by ambitious mujahedin guarding the JIA-commander of Nahrin, Abdul Hay Haqjoo, whom we wanted to see, but he was on his way to the trial in Taloqan and sent his deputy to take care of us.

The political situation around Ishkamish and in north-east Baghlan province was unclear. Schools were closed and some villages were reported to be HIA-strongholds. HIA was then said to obstruct the roads for JIA-vehicles.

I visited the clinic in Nahrin, where I met Dr Sahar, responsible for health in Shura-e-Nizar Northeastern Zone. The city of Nahrin was liberated very soon after the Soviet occupation in 1979, with the war thereafter for some years limited to the area around the Soviet garrison in Nahrin valley. Nahrin was well reconstructed.

We went from Nahrin to Andarab by jeep and horses. From the small village Unumak we entered the pass to Panjshir, arriving in Parandeh. We stayed in Bazarak for a few days and saw the hospital in Rokha, and a newly built hospital located partly in caves. We visited an OPD-clinic and infection ward in Anawa, which has a ward for women patients transferred from the hospital in Rokha.

The survey work in the Panjshir was affected by the fact that the valley had been evacuated on Massoud's order. There were patients only in the cave-hospital. The other clinics, as well as all schools, were emptied and the people had withdrawn to caves. Massoud, who started an offensive on the 11th of September, feared retaliation against the Panjshir valley.

The Panjshir was the most destroyed area we saw. Families had resettled among the ruins, but in many parts of the valley four out of five houses seemed empty. Many orchards were destroyed, and a lot of the agricultural land in the narrow valley was not in use. There are still a lot of mines in Panjshir. The prices in the bazaar, especially of bulky goods, were higher than elsewhere reflecting the high costs of transportation.

We left Panjshir by the way of Paryan, and via Topkhana we reached Pakistan in four days on our Panjshiri horses. The last night snow was falling and we barely made it to Shah Sidim in time for Professor Rabbani, who had been in Topkhana to consult with Commander Massoud, to give us a lift through the checkposts to Chitral. We arrived in Chitral Sept 22, four weeks and five days after we had left.

5. THE HEALTH CARE PICTURE

Detailed information about the hospitals and clinics visited can be found in the Detailed Report. In this section I would like to address health in the North-East region, determine what the health system can offer the inhabitants, and identify where improvements can be made.

It is important to realize that the situation in the Afghan countryside has changed. Just a few years ago the situation was such that almost anyone who showed some medical knowledge and was prepared to work in Afghanistan would be selected as a recipient of medicines and other materials by various health NGOs.

At the time it was important to have a lot of first-aiders, with reasonable qualification, to assist wounded people in remote and isolated areas. Their help was better than nothing, and nothing was often the only alternative.

Today the situation is different. Vast areas are liberated, and some major cities, and their hospitals, are in the hands of the mujahedin. The bombardment of many areas is much diminished or non-existent. Some healthworkers report that a majority of their patients are civilians, many of them women and children.

The first-aiders are maybe no longer "better than nothing". They tend to distribute large amounts of medicines to relatively healthy people, while offering little to counteract some of the biggest factors in morbidity and mortality: infectious diseases among children, malnutrition in children and pregnancy-related problems. Unmet needs include disease prevention, e.g. health education and vaccination, as well as advanced medical care, e.g. Caesarean sections.

The NGOs need to adjust their field operations to the fact that there are hospitals, roads, vehicles and a civilian leadership in this area. This work has already begun. People are concerned with upgrading their staff and changing the content of the standard drug lists to fit a civilian population. Vaccination programmes have been started. Some health NGOs are considering sending expatriate staff to the major hospitals to work together with the existing Afghan staff.

5.1 HOSPITALS: LOCATIONS AND PROFILES

There are six hospitals in the area. The following is a brief description of their location and their relation to other facilities:

1. Yokh

Location: in a small village 3 hours drive south of Farkhar. Nearest health facility for people as far south as the lower Piw-valley. They have 1.5 days walking distance to Yokh. The road is passable for motor vehicles from Pol-e-Piw (JOG: Gawkul), from which it takes 3-4 hours to reach Yokh. To get to Pol-e-Piw from the villages in the southern part of Piw takes about four hours on foot.

Travel time to Pakistan from Yokh is at least five days by way of Topkhana, which is the fastest route. No vehicles can drive between Pol-e-Piw and Pakistan.

Travel time to Rokha in Panjshir would be no less than three days using motor vehicles when possible and going by way of Anjuman.
I do not know how long it would take to reach Khel Ab.

The hospital is run by Shura-e-Nizar, Northeastern Zone.

2. Taloqan

Location: in the capital of Takhar province, center of a densely populated area. It is located 2-3 hours' drive from Farkhar, 5-6 hours from Yokh and about 4-5 hours from Keshim. Westward it is less than an hour to Khanabad hospital. The government hospital in Kunduz is less than two hours away. The roads in the area are good.

The hospital is run by Shura-e-Nizar, Northeastern Zone.

3. Khanabad

Location: in Khanabad city. It is less than an hour away from Kunduz city and the government posts are less than half an hour outside the city. Taloqan hospital is less than an hour away.

The hospital is run by a Shura of five parties (Ittehad, HIA, JIA, Harakat, Mahaz-e-Milli). It is on friendly terms with Shura-e-Nizar.

4. Rokha

Location: a village in central Panjshir valley. It takes four or five days to reach Pakistan. Travel time to Yokh is probably at least three days, and it takes about as long to reach the small clinic in Nahrin. To Khel Ab it is probably four or five days, but I know nothing about the roads in the Khost-Fereng area. The nearest government hospital is Charikar in Parwan, which is three hours away by car. The "cave hospital" of Panjshir is one hour away from Rokha. The hospital is run by Shura-e-Nizar, Central Zone.

5. The "cave hospital" in the Panjshir Valley

Location: Outside a village one hour's drive south of Rokha, and about an hour north of government holdings at Gulbahar. The hospital is newly built as an annex of Rokha, but situated in a place regarded safe for bombardment. Parts of the hospital are in caves. I has just opened and is still partly under construction.

The hospital is run by Shura-e-Nizar, Central Zone.

6. Khel Ab Hospital

Unfortunately I could not visit Khel Ab. The hospital is located north of Khost Fereng, a little north of a place called Dahana. Before the liberation of Taloqan this hospital was regarded the center hospital of Shura-e-Nizar Northeastern Zone.

5.2 CLINICS: LOCATIONS AND PROFILES

1. Nahrin

Location: Nahrin City. If the roads are safe it takes six hours by car to reach Taloqan, otherwise three days. People we met had spend three days walking from Khel Ab. Also Rokha is three days away, and that road is mostly not usable for motor vehicles. The government hospital in Baghlan is two hours away by car.

2. Farkhar

Located in Farkhar city, three hours by car from Yokh, two to three hours from Taloqan and two hours from Keshim and with the government hospitals in Faizabad and Kunduz city within half a day's journey by car (if the road to Faizabad is open).

5.3 EXISTING LINKS OF REFERRAL

(for details see the Detailed Report under each hospital)

From Yokh patients are referred mostly to Peshawar for medical investigations (X-ray, laboratory) or for paraplegia. Sometimes patients are referred to the government hospital in Kunduz city. Yokh receives patients from Farkhar, Taloqan and Keshim in Badakshan, mainly war wounded.

From the clinic in Farkhar patients are referred to Yokh (war wounds) and to Peshawar (osteomyelitis, paraplegia). No patients are referred to Kunduz. Farkhar receives no patients from others.

From Taloqan patients are referred to Yokh (for abdominal surgery), and to Kunduz (war wounded child who needed blood transfusion). They have never referred to Pakistan. Taloqan receives patients from Yokh but not from Farkhar.

From Khanabad many patients are referred to the nearby government hospital in Kunduz city. They are women, children and older persons needing abdominal surgery. Two patients have been referred to Pakistan for neurosurgery. Patients (internal medicine investigation) have been received from Taloqan.

From Nahrin "very few" patients are referred to the government hospital in Baghlan, examples being old men in need of abdominal surgery. They have referred to Khel Ab for abdominal surgery and to Pakistan for tuberculosis and paraplegia.

From Rokha no patients are referred to the government hospital in Charikar. On the contrary, Rokha receives patients, though not officially referred, from Charikar, and even from Kabul. Rokha refers to Pakistan for protheses, psychiatric illnesses, osteomyelitis and eye diseases.

The "cave hospital" in the Panjshir Valley is in this sense a part of the hospital in Rokha.

Comments on referral links

The hospitals in Yokh and Khel Ab (both located in small but safe places) have had the best facilities for surgery in the Northeastern Zone and Rokha in the Central Zone. However Yokh has normally no capacity for abdominal surgery.

Due to the, till now, low capacity of Taloqan, this hospital has not been operating as a primary referral center. It is reasonable to convert Taloqan to the primary hospital of the Northeastern Zone. The city is big, there are many people living close to the hospital, and if the roads are safe it is accessible within half a day from Nahrin, Khanabad, Farkhar, Keshim and Yokh, and in eight hours from Warsaj.

In general, investigation of internal diseases seem to be a problem. Taloqan occasionally refers patients to Khanabad, and Yokh refers to Pakistan. Only one clinic, Farkhar, mentions tuberculosis as a reason of referral, although neither do the other clinics and hospitals have antiTB-drugs.

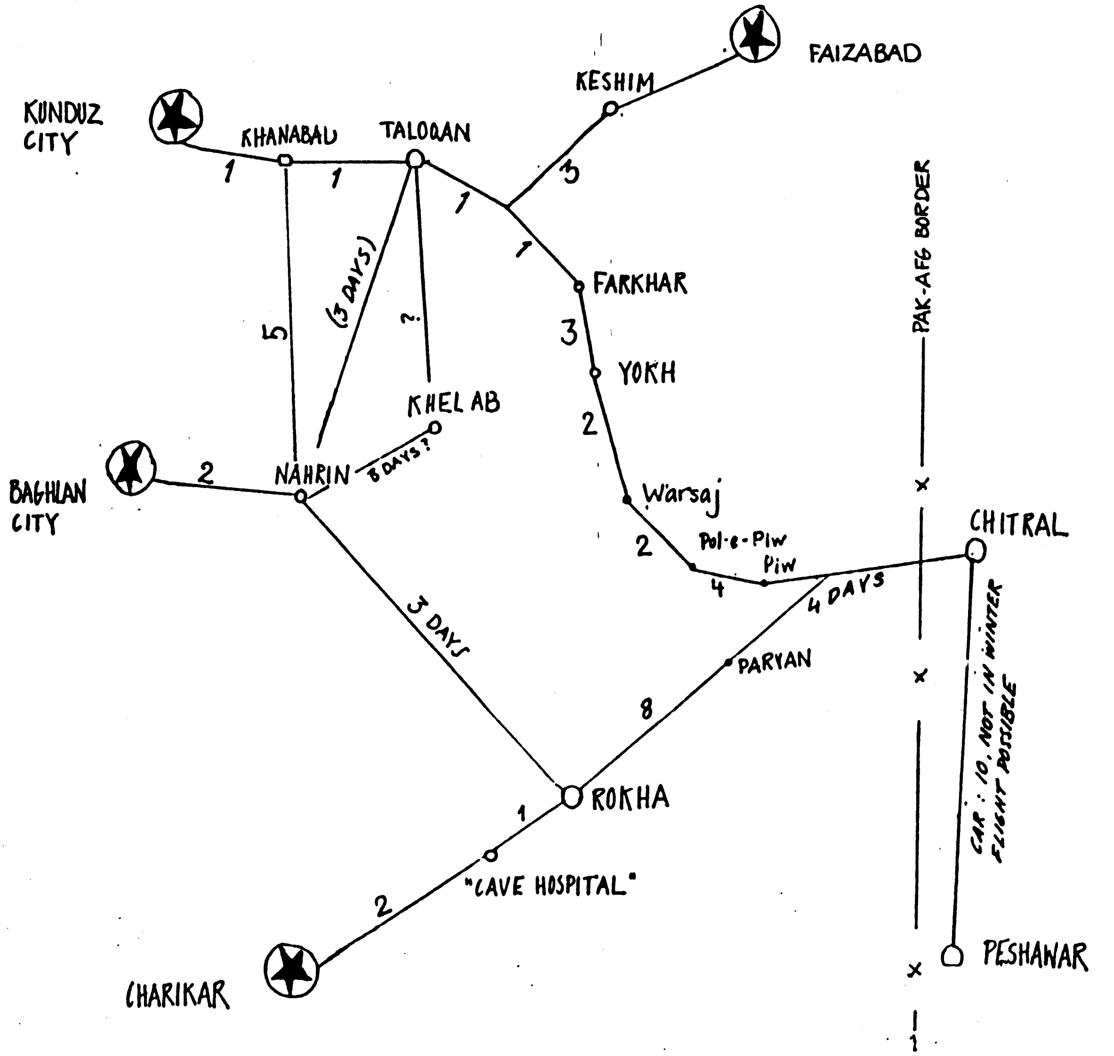


Figure: Schematic drawing of possible links of referrals with the hospital in Taloqan as the primary center. The figures indicate how many hours that are now approximately needed between two locations, using the best available means of transportation. Unfilled circles mark places with clinics. Circled stars mark government hospitals. See text above for further explanation.

THE COORDINATION OF MEDICAL COMMITTEES

CMC MEDICAL MONITORING SURVEY

GENERAL REPORT OF CLINICS MONITORED IN NORTH-EAST AFGHANISTAN

TAKHAR, KUNDUZ, BAGHLAN, AND KAPISA PROVINCES

AUGUST-SEPTEMBER 1989

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5.4 SERVICES

Surgery

The facilities (operation theater, equipment, sterilization) seem reasonably satisfactory in: Yokh, Taloqan, Rokha, the "cave hospital" of Panjshir, and maybe soon in Khanabad. Most likely there are good facilities also in Khel Ab.

Amputations are performed in: Yokh, Farkhar, Taloqan, Khanabad, Nahrin, Rokha, in the "cave hospital" and in Khel Ab (not visited). I think amputations should be discouraged in Nahrin and Farkhar. The facilities are not satisfactory and neither place has an M.D.-doctor. And, at least in the case of Farkhar, good referral facilities are accessible within a few hours (Yokh, Taloqan). If the roads are safe Taloqan is only six hours away from Nahrin.

Laparotomies are performed in Rokha, the "cave hospital", Khel Ab, and Yokh. There are four or five graduate doctors in the area who have enough experience to do abdominal surgery: Dr Walid (Rokha, "cave hospital", specialized in surgery), Dr Mujtaba (Rokha, "cave hospital", trained by Dr Walid), Dr Saida Ismael Said (just moved to Taloqan from Rokha where he was trained by Dr Walid), Dr Amir Mohammed (Khel Ab) and maybe a surgeon by the name of Assadullah Qamal will arrive in Taloqan from Kunduz.

This means that, until now, only Rokha and Khel Ab have had capacity for abdominal surgery. In Yokh, it has been performed when Dr Walid has visited, and reluctantly once by the doctor there, Abdul Basir. The priority from Shura-e-Nizar has been to get the capacity upgraded in Taloqan, and therefore Dr Said has been moved from Panjshir, and Dr Qamal hopefully recruited.

No one is performing Caesarean sections. This means that much of the mortality associated with childbirth is unavoidable. If antenatal programmes are started at the clinics in Taloqan and Nahrin, it is crucial to establish surgical capacity for Caesarean sections in Taloqan. The most important aim of a good antenatal programme is to predict and take care of lethal complications, and if these can not be handled properly (often demanding surgery) the benefit, in terms of saving lives, of having an antenatal programme will be largely limited to prevention, such as distribution of iron and vaccination against tetanus.

Practically, the most reasonable thing might be to invite one of the surgeons from Taloqan to Peshawar to upgrade this skill. Another alternative is to send a female expatriate surgeon to Taloqan. She would be permitted to operate on women (and seeing the results, the community might less reluctantly permit also male surgeons to perform Caesarian sections), and she would be able to teach the young and enthusiastic Dr Said.

X-Ray

In Yokh the X-ray machine is said to be "on the way". In Taloqan there is no X-ray, nor in Khanabad. In Rokha, two X-ray machines have been delivered by SCA, but they are not working. A new one has been given by NCA, but that one is also not working presently. There is no X-ray in the "cave hospital". Khel Ab is said to have an X-ray machine. The only working machine I saw was at the clinic in Nahrin, where 2-5 pictures are taken daily.

Laboratory

In Yokh there is no laboratory, and no microscope. There is no laboratory or microscope in Farkhar. In Taloqan there is a microscope, and a (female!) laboratory technician is hired and gets salary, but she is not yet working. In Khanabad there are three microscopes, but the laboratory is not working because the technician has been wounded in bombardment. In Nahrin there is one microscope and a technician who seems to do only malaria tests. In Rokha there is a laboratory that is used mainly for stool exams.

Blood transfusions have been given in Rokha, and then often with the surgeon or the assistant donating the blood!

Pharmacy

The pharmacies were generally rather well kept. Everyone complained of lack of injectable drugs, especially antibiotics. Lots of ferrous sulphate and terramycin eye ointment was found in the pharmacies. Patients were said not to like tablets, especially not white ones without original wrapping. Injectable vitamins were much prescribed, also for grown-ups.

Many pharmacies had the "sun-and-moon" medicine packets for illiterate patients, but I saw no pharmacist write the necessary figures on the bags.

Hospitalization of Female Patients and Children

Most of the hospitalized patients I saw were war wounded adult men. The hospitals still have the character of war-hospitals. I saw no children hospitalized, and no women.

There is a special room for two or three female patients in Taloqan, and for one or two in the infectious ward in Anawa associated with the Rokha hospital. Yokh can hospitalize women in a staff room, and maybe this would be possible also in Nahrin. In Khanabad hospital the wards are being organized.

In Yokh female patients have been treated for post-partum hemorrhage. In Taloqan the female staff can help with deliveries at the hospital.

Out-Patient Department

All the clinics and hospitals had OPD's where doctors saw 50-150 patients daily. Many of the patients were women and children. In Nahrin the clinic was open to women only on Saturdays. In the other clinics women could come every day.

An impression is that examinations were very brief. A lot of patients complained of problems such as "generalized body pain", "feet-pain", "palpitations" and other symptoms that might be psychosomatic. No attempt was made to discuss this with the patients, and the patients were happy to get drugs.

In this stream of physically rather healthy patients, I saw a minority of patients with obvious and severe problems such as advanced skin infections, severe malnutrition, grave anemia, eye diseases and dehydration. These patients generally seemed to get about as much attention as the healthier ones. The doctors do not take the time, or have not the possibility, to make a selection in their "150-patients-in-three-hours" flow.

Examination of Females

Accepted "doctors", that is graduate doctors and paramedics, were generally able to examine women. The women lifted their veils i front of the doctor, who could use a stethoscope through their clothing and who could make abdominal exams with clothes on and the patient usually standing in front of the sitting doctor. It seemed that the more serious the patient's condition, the closer the examination accepted. (Dr Walid in Rokha told how he, when he arrived more than a year ago, had to examine a woman that was lying on the examination table under a blanket, by asking her husband questions. The husband would then ask his wife, who would answer from under the blankets to her husband, who in turn reported to the nearby standing Dr Walid.)

No male doctor or paramedic reported that he was able to make gynecological examinations. This means that only in Nahrin and Taloqan, where there is female staff, can gyne-exams be performed and deliveries supervised.

Dental Care

At the Farkhar clinic and Taloqan hospital teeth can be extracted. A real M.D. dental surgeon is present in Rokha where there is a clinic at the hospital that provides impressive full dental services including the making of artificial teeth. The IMC students at Nahrin pull out teeth, and say they can also fill and make artificial teeth, though I did not see any equipment for this. At Yokh and in Khanabad there are no dental services.

Health Manpower

(For a list of name, assignment and affiliation of health workers please see section 7 "Inventory of Health Workers", which includes 93 names.)

At the clinics I visited a total number of 17 graduate doctors were present. One of these, Dr Mohammed Alem Dardmal, is the representative of the interim government in Kunduz province and is not working as a doctor at Khanabad hospital, which means there are 16 active graduate doctors. M.D.-doctors are present at Yokh, Taloqan, Khanabad, Rokha and at the "cave hospital of Panjshir". I saw only two clinics without M.D.-doctors: Nahrin and Farkhar. In the city of Nahrin there are, however, two M.D.- doctors working privately. No real effort had been made to recruit them to the clinic. M.D.-doctors in private practice were not reported in any other city.

I met quite a few paramedics trained in Peshawar. At the hospitals, however, the staff is often trained locally or have prior education from Afghanistan.

Generally the clinics and hospitals seemed to have enough staff, lacking persons with specialized training more than general nurses or paramedics. Many health workers were working at the clinics without salary. They had some kind of "mujahedin-status", with the commanders giving them some assistance when needed. (For salaries, please see the Detailed Report).

Training of Health Workers

In Rokha the doctors produce a newsletter on treatment of various diseases and distribute that among themselves. In Rokha Dr Walid has trained Basic Health Workers before, and uses them at the hospitals. He has also upgraded the surgical skills of two graduate doctors, and has made one of them, Dr Mujtaba, head of the surgical department in Rokha. In Khel Ab 25 students are said to be trained for three months in a programme supported by MSH.

Green Books and Record-keeping

The green book seen at Yokh hospital seemed reasonably accurate. Other green books were incompletely or falsely filled out. Very often the books were filled out in advance, with name, sex and age (written more exactly than patients generally answer: most women answer "20", "35" or "50", not "27") of patients, and the date of their future visit filled out.

Sometimes the doctor filled out the diagnosis (e.g. Dr Rangmal, Rokha) and would complete with the information about prescribed drugs "later when there is time". At Taloqan a special person (Ali Ahmad, untrained) was writing in the green books sitting next to the pharmacist. He used information from the prescriptions, thereby lacking diagnosis. The same system was used in Khanabad where Jamad Gul filled out the green books from prescriptions. Some medical person probably advised on suitable diagnoses later. At Farkhar two or three paramedics were seeing patients at the same time, but there was only one green book used and it was filled out in advance.

In Nahrin the green books were taken by the IMC-monitor that visited at the same time, and I did not see them.

I made no detailed studies of the green books. At Yokh this was due to lack of time, but later I decided not to deal much with these falsifications.

The use of green books should be stopped along with the work (presently ongoing at CMC) of making statistics from them. Another, ethical reason, is that in asking for this information many young health workers are encouraged to falsify information in order to satisfy the NGOs.

At Rokha, Dr Walid has developed the following usable records and forms: IPD patient record, referral record, operation record, pharmacy record (prescribed drugs), physiotherapy chart, and laboratory stool report. These have been printed in Peshawar. Dr Walid also showed organizational charts of the structure of the hospital and clinics, with names of responsible persons. The organizational charts were signed by Commander Massoud, indicating that they have influenced plans and decisions.

Patient Fees

No clinic or hospital took fees, but distributed the medicine free of charge. Often, though, patients were directed to buy some medicines themselves in the bazaar.

6. PREVALENCE OF DISEASE

The official under-five mortality rate (U5MR) in Afghanistan is the highest in the world; 304 out of a thousand children never reach their fifth birthday (4). The high mortality is associated with the high prevalence of malnutrition and infectious diseases among Afghan children, as well as with war-associated trauma.

To acquire a better understanding of the health problems in Afghanistan it is important to try to determine the prevalence of important diseases.

Therefore, four surveillance studies were planned by the monitors of the fourth CMC-mission:

1. MALARIA: Study of the number of smear-positive patients, determination of the species of the malaria parasites, and determination of the number of asymptomatic carriers amongst school children.

2. MEASLES: Study of the number of vaccinated children in four areas of Badakshan where MSF France had vaccinated last winter.

3. MALNUTRITION: Study of the prevalence of malnutrition in children aged one to five, using upper arm circumference (UAC).

4. GOITER: Study of the prevalence of goiter in adult women.

Unfortunately the malaria-survey, due to the absence of the second CMC physician monitor, and the measles-survey, due to the change in route, could not be carried out. (See section 4 "A Narrative of The Journey" for explanation).

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4. UNICEF: The State of the World's Children, 1989

6.1 MALNUTRITITION IN CHILDREN

The objective was to try to estimate the prevalence of malnutrition in children aged one to five.

Methodology:

I spent two days in Taloqan, two days in Khanabad and one day in Nahrin sitting with the OPD-doctor. I tried to examine all the children between 1 and 5 that showed up in that room during the clinic period when the doctor was seeing patients.

Results:

I checked the UAC of 114 children. Of these sixty (53 %) showed malnutrition, measured as a UAC of less than 13,5 cm. Sixteen children (14 %) showed severe malnutrition with a UAC of less than 12 cm.

The sample size is too small for definitive conclusions, but it seemed that malnutrition was a larger problem in Khanabad where 8 out of 39 children were severely malnourished, and in Taloqan where 7 out of 41 children were severely malnourished, than in Nahrin where only 1 out of 34 children was severely malnourished.

I could see no systematic differences between girls and boys.

Discussion:

Frederic Tassilly, MSF-France, used the same method in Badakshan (1) the winter 88-89 for checking malnutrition but in association with a vaccination campaign, and therefore avoided the bias I encountered of seeing primarily sick children. He found a prevalence of malnutrition of 37 per cent, with severe malnutrition in 10 per cent of the children seen (N = 18 144).

The results of my limited study indicate that the situation is similar in this area. My impression is that severe malnutrition was associated with poor weaning practices and infectious diseases such as measles.

The price of wheat, also in relation to a labourer's wages, is higher in Nahrin than in Khanabad and Taloqan (see appendix 3), which indicates that lack of knowledge is a more important factor contributing to malnutrition than lack of food. The effects of war could also be a factor in malnutrition; both Khanabad and Taloqan were liberated just one year ago, while Nahrin city has been free since the beginning of the war.

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5. cf. # 3, Frederic Tassilly, page 9

6.2 GOITER IN WOMEN

The objective was to estimate the prevalence of goiter in women aged 15-45.

Methodology:

At the same days as I checked children for malnutrition I also checked women for goiter. All women between 15 and 45 that entered the OPD-room were checked. A palpable, though not visible ("group 1 a superior"), goiter was registered as goiter, with gradations according to a standard goiter scale (6).

Results:

I checked 142 women. Sixty women (42 %) had evidence of goiter. Two of the women said they had a deaf child. I saw both of these children, and one was a four-year old, deaf since one year with a history suggesting meningitis. This child was mentally affected. The other child was a boy of ten years. He had goiter and so had his mother. He was deaf since birth but seemed intelligent and normally developed. He could not be classified as a cretin. A photograph of the child and his mother is included in the Picture Report.

Discussion:

Therese Gandon, MSF-France, performed in 1988-89 a study on the prevalence of goiter among 2823 women in Badakshan aged 2 - 80 years (7). In this group she found a prevalence of goiter of 43 per cent.

In my limited study I obtained similar results, indicating that Iodine Deficiency Disorders (IDD) are endemic in the general North-East region. (A prevalence of 30 % at adult age is a criteria for endemicity (8)).

The fact that I saw no cretin children, despite the high prevalence of goiter in fertile women may be due to the high rate of child mortality. The cretin children are probably more likely to die, and therefore we do not see them.

I asked in all bazaars for iodized salt, but found only non-iodized mountain salt. Iodine can be also distributed in oil, injected or taken orally (9). A programme for iodine distribution should be considered.

NOTE: If the prevalence of goiter is 40 per cent, one needs to examine 150 persons to get an acceptable fault of 20 per cent, with a confidence interval of 95 per cent (3)).

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6. Thanh Nguyen Duc, AVICEN: personal message
7. cf. # 2, Therese Gandon, page 9
8. cf. # 1, Thanh Nguyen Duc, page 9
9. Basil S. Hetzel: The Prevention and Control of Iodine Deficiency Disorders

7. INVENTORY OF HEALTH WORKERS

These are the health workers working at the clinics I visited. Note that hospitals in Yokh, Taloqan and Rokha, and the clinic in Farkhar, are administered by Shura-e-Nizar. Different NGOs are contributing to Shura-e-Nizar and it is sometimes difficult to see exactly who is associated with what NGO. MSH is paying salaries at Taloqan, and SCA at Farkhar, Yokh and Rokha.

Non-Medical Staff are not included here. For details, see Detailed Report. A list of health workers working at clinics that I heard of but did not visit is included in the Detailed Report

M.D. Medical Doctor
pm paramedic, person working as a doctor who is not M.D.
RN college trained nurse
n nurse
MDV college trained midwife
mv midwife
lab laboratory technician
spv malaria supervisor
X X-ray technician
DEN college trained dentist
den dentist
pharm pharmacist
adm medical staff who is now mainly working administratively
vet veterinary
anes anesthesiologist
EKG electrocardiogram assistant

Name and Assignment	Affiliation	Location	Seen
1. Abdul Basir, M.D.		Yokh	yes
2. Mohd Wasir, pm	FM	Yokh	yes
3. Mir Ahmad, pm	FM	Yokh	no
4. Abdul Rahman, pm	Union Aid	Yokh	no
5. Abdul Jabar, pm	"Arabs"	Yokh	no
6. Mohd Sadeq, pm		Yokh	no
7. Gada Mohd, pm	SCA	Farkhar	yes
8. Sadrudin, pm		Farkhar	yes
9. Hekmatullah, pm		Farkhar	yes
10.Halim Khan, pm		Farkhar	no
11.Hamidullah, pm	MTA 87	Farkhar	no
12.Mokhim Shah, pm, adm (RN)		Taloqan	yes
13.Abdul Ahad Atef, M.D.		Taloqan	yes
14.Abdul Afiz, pm	MSH 1074	Taloqan	yes
15.Rasool Mohd, pharm		Taloqan	yes
16.Shah Mahmood, pm	UAAR, KRCS	Taloqan	yes
17.Mohd Aziz, pharm		Taloqan	yes

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CMC Monitoring Mission # 5 to North-East Afghanistan

18.Sarajudin Dashti, M.D.		Taloqan	yes
19.Saida Ismael Said, M.D.		Taloqan	yes
20.Abd.Khaleq Nazari, M.D.		Taloqan	no
21.Ali Ahmad, pm	at MTA now	Taloqan	no
22.Sheer Agha, n		Taloqan	
23.Abdul Basi, n		Taloqan	
24.Abdul Manan, n		Taloqan	
25.Nehmatullah, n		Taloqan	
26.Abdul Rahman, n	at MSH now	Taloqan	no
27.Abdul Karim, n		Taloqan	
28.Mohd Qasem, n		Taloqan	
29.Habib Rahman, n		Taloqan	
30.Afizullah, n		Taloqan	
31.Shamsudin, n		Taloqan	
32.Monija, RN		Taloqan	no
33.Homaira, mv		Taloqan	no
34.Rahima, mv		Taloqan	yes
35.Anisa, mv		Taloqan	yes
36.Shahi, RN		Taloqan	no
37.Hafiza, lab		Taloqan	no
38.Abdul Aziz, X		Taloqan	
39.Rostam Ali, spv		Taloqan	
40.Najibullah, den		Taloqan	yes
41.Abdul Rahag Danai, M.D.		Khanabad	yes
42.Muhammad Shafi, RN		Khanabad	yes
43.Akhtar Mohd, pm	FM	Khanabad	no
44.Janar Gul, n	MSH 88	Khanabad	yes
45.Abdul Matin, pharm	SCA before	Khanabad	yes
46.Monir, lab		Khanabad	no
47.Abdul Rahman, adm (spv)		Nahrin	yes
48.Mohd Jaffar, pm, X		Nahrin	yes
49.Abdul Zamad, spv		Nahrin	yes
50.Mohd Daoud, dent		Nahrin	yes
51.Saifullah, dent		Nahrin	yes
52.Abdul Basir, pm		Nahrin	yes
53.Abdul Mohd, pharm		Nahrin	yes
54.Abdul Khalil, pm	IMC 88	Nahrin	yes
55.Abdul Rasuq, pm	IMC 85	Nahrin	yes
56.Sayed Habib, pm	SCA	N, Qodri	yes
57.Abdul Qader, pm	IMC 88	Nahrin	no
58.Mohd Ashem, pm	IMC 88	Nahrin	no
59.Mohd Azan, pm	MSH 87?	Nahrin	no
60.Sayed Rahman, pm	MSH 87?	Nahrin	no
61.Abbas, pm	MSH 87?	Nahrin	no
62.Mira Jamad, pm	FM 88	Nahrin	no
63.Nasrullah, vet	GAF?	Nahrin	no
64.Aminudin Shafajo, M.D.		Rokha	yes
65.Abdul Wasir Rangmal, M.D.		Rokha	yes
66.Ghulam Mujtaba, M.D.		Rokha	yes

67.Najibullah, M.D.		Rokha	yes
68.Walid, M.D.		Rokha	yes
69.Abdul Zahmad, M.D.		Rokha	no
70.Mohd Akbar, M.D.		Rokha	yes
71.Ahmad Shah Shukomand, M.D.		Rokha	yes
72.Zaid Gul, M.D.,DENT		Rokha	yes
73.Amin, M.D.	SCA	Rokha	yes
74.Sobkhan, pharm		Rokha	yes
75.Bari Alei, n		Rokha	
76.Wahidullah, anes	FM 88	Rokha	*)
77.Mohd Alim, pm		Rokha	yes
78.Zohoruddin, pm	IMC 86	Rokha	yes
79.Zia-ul-Haq, n		Rokha	
80.Mohd Reza, n		Rokha	
81.Abdul Zamad, n	Sudanese	Rokha	
82.Aqa Gul, pharm		Rokha	
83.Abdul Rasak, n		Rokha	
84.Habibullah, dent		Rokha	
85.Mohd Shafi, dent		Rokha	
86.Noor Agha, dent		Rokha	
87.Ghulam Rahman, lab	IMC/AHSAO	Rokha	no
88.Amanullah, pm		Rokha	
89.Abdul Baqi, X	IMC/AHSAO	Rokha	no
90.Faiz Mohd, EKG	IMC/AHSAO	Rokha	no
91.Wali Mohd, pm	IMC 86	Rokha	
92.Safi Ahmad, n		Rokha	
93.Mahibullah, n		Rokha	

Note: Rokha and the "cave hospital" of the Panjshir Valley, which is newly opened, have the same staff. The hospital in Rokha was evacuated at the time of the visit. Some staff members were at the "cave hospital" and some I did not see.

*) I saw, and took a letter to Peshawar, from one FM-student at Rokha. If Wahidullah is the only FM-student there it should have been him.

8. EDUCATION IN THE AREA

Primary and secondary education for boys is a high priority in the area. I saw no girls' schools. Rumours are, there is one in Taloqan and a secret one in Panjshir. No religious schools ("madrasa") are included below, but only other schools ("maktab"). A majority of the schools have only three grades.

In Warsaj there are five schools run by 'Afghanistan Education Committee (AEC), a branch of SCA, as well as several other schools run by Shura-e-Nizar.

In Nahrin the Education Committee of the civil administration of commander Abdul Hay Haqjoo, is running 44 schools, 24 paid by University of Nebraska, and 20 by AEC.

In Panjshir the Education Committee for Shura-e-Nizar Central Zone claims to run 120 schools. Of these, 16 are supported by AEC and 8 by University of Nebraska and the rest by Shura-e-Nizar alone. Two of the AEC schools are high schools with up to seventh grade.

In Farkhar one school was reported.

In Taloqan there was one primary school and one high school, and some people said there was also a girls' school with three grades run by Shura-e-Nizar.

In Khanabad the University of Nebraska just started three schools that are run by the Khanabad Shura. There was said to be a high school in the city.

In Ishkamish the AEC schools were closed down due to the HIA-JIA fighting.

The responsible persons of the Education Committees are:

Shura-e-Nizar Northeastern Zone: Pohand Fazel
Shura-e-Nizar Central Zone: Cherkhan Siddiqi
Nahrin: Kohsari

9. AGRICULTURE IN THE AREA

Agroeconomically, the area can be divided into three zones (10):

The valleys of the Hindu Kush (Farkhar, Nahrin, Andarab) have substantial cultivated areas but the production of wheat just barely supports its inhabitants. The valleys export nuts, fruits and labour.

The Northern Foothills is an area stretching from Keshim to Andarab. At the altitude of 1,000 - 2,000 meter low-yielding rainfed wheat is produced.

The Northern Plains are located around the river systems around Khanabad and Kunduz. An extensive irrigation system feeds a highly productive agricultural zone that traditionally has been food-exporting and labour-importing.

In terms of destruction, Panjshir followed by Khanabad were the most war-destroyed areas we saw.

Generally, seeds, fertilizer and farm power animals are available in the area. The fertilizer comes from Mazar-i-Sharif, Balkh province.

Responsible persons in the agricultural committees are:

Shura-e-Nizar Northeastern Zone: Painda Mohammed
Shura-e-Nizar Central Zone: Engineer Qasim
Nahrin: Engineer Qahar (responsible for reconstruction)

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10. Louis Dupree: Afghanistan (Princeton University Press, 1978).

10. POLITICS IN THE AREA

10.1 The Internal Conflict

The so-called Farkhar incident of July 9th 1989, where some 30 Jamiat men were killed by the Hezb-Islami commander Sayed Jamal, shadowed our trip. It was the conflict between HIA and JIA that prevented us from going to Badakshan. In the Western parts of Takhar, around Ishkamish, the roads were unsafe due to this conflict.

Fighting between JIA (Massoud) and HIA had been going on in Takhar following the incident up to early August. In fact, all the wounded people we saw in hospitals outside Panjshir were wounded in HIA/JIA fighting or by mines. Only on direct questions did anyone, with the exception of commander Massoud, talk about the enemy being the government.

As we left Taloqan the interim government delegation arrived for the trial of Sayed Jamal.

It seems that Commander Massoud and JIA controls most of Takhar (for example the whole Farkhar valley), with the exception of the area around Ishkamish. Hezb-Islami is present in Khanabad (where they participate in the Shura) and in Badakshan.

Unfortunately we met no prominent HIA-commander.

In the North-East Shura-e-Nizar controlled area most people are Tadjik. Around Khanabad there are many Pashtuns, grandchildren of people that moved from Logar and other provinces in the "Pashtun-crescent" years ago. The strong commander of Khanabad, Amir Mohammed, is Pashtun and belongs to Ittehad (Sayyaf). He controls the area from the border between Takhar province and Kunduz province, and he is on friendly terms with Shura-e-Nizar.

The Panjshir valley is a stable JIA-area, under the control of the "Amir of Panjshir", commander Sar Anwar Mohammed (Ahmad Shah Massoud is referred to as the "General Amir").

The strong JIA-commander of Nahrin, Abdul Hay Haqjoo, is in military matters cooperating with Shura-e-Nizar (Massoud), but is independent in some civilian matters. For example: the teachers are better paid than those of the Shura-e-Nizar, and there is a separate Education Committee in Nahrin. The clinic in Nahrin gets its medicines straight from Peshawar, and not via the Shura-e-Nizar depot that supports the Shura-e-Nizar clinics.

10.2 The Shura-e-Nizar

In 1985 commander Ahmad Shah Massoud invited the important commanders to form a civil administration for the north. Most of the commanders were JIA, but commanders from HIA (Khales), Harakat, and Mahaz-e-Milli were also present.

The Shura-e-Nizar is divided into four zones:

The Central Zone: Panjshir, Parwan, Bamiyan, Northern Kapisa, Northern Kabul.
The Northeastern Zone: Badakshan, Takhar, Kunduz, Baghlan.
The Northern Zone: Samangan, Balkh, Jowzjan, Faryab.
The Eastern Zone: Laghman, Southern Kapisa, Southern Kabul.

(Very often the Northeastern Zone is simply referred to as the Northern Zone, and sometimes the Central Zone is called the "Centraleastern Zone").

The Shura-e-Nizar is organized in committees. The committees plan, coordinate, support and implement the work in their respective areas. Donors, including foreign donors, are required to assist the committees, which implement the work.

My impression of Shura-e-Nizar is that the organization is very much centered around Ahmad Shah Massoud, and that a lot of decisions that are strictly civilian still are made by him personally. The quality of the committees seem to vary. In health, both Dr Sahar of the Northeastern Zone, and Dr Rahim Dad of the Central Zone (who has succeeded Dr Walid) make an impression as very hard-working and reliable persons.

11. APPENDICES

11.1 Journey Date Listing

Note: All geographical names are spelled in accordance with the Swedish Committee Map "Afghanistan", or in case the names are not there in accordance with the Combined Joint Operations Graphic Map (JOG).

August 1989:

20	Peshawar-Chitral
21	Chitral-Shah Sidim
22	Shah Sidim-Maghnawul
23	Maghnawul-Koran (Koranomunjan)
24	Koran-Piw
25	Piw-Khanaqa (Warsaj)
26	Khanaqa
27	Khanaqa-Farkhar
28	Farkhar-Taloqan
29	Taloqan
30	Taloqan-Khanabad
31	Khanabad

September 1989:

1	Khanabad
2	Khanabad
3	Khanabad-Taloqan
4	Taloqan
5	Taloqan-Bangi
6	Bangi-Ishkamish
7	Ishkamish-Nahrin
8	Nahrin
9	Nahrin
10	Nahrin
11	Nahrin- Andarab
12	Andarab
13	Andarab
14	Andarab- Dolana
15	Bazarak (Panjshir, not in maps)
16	Rokha
17	Bazarak
18	Bazarak-Paryan
19	Paryan-Anjuman
20	Anjuman- Koran
21	Koran-Maghnawul
22	Maghnawul-Chitral
23	Chitral-Peshawar

11.2 TABLE OF ABBREVIATIONS

AEC	Afghanistan Education Committee (associated with SCA)
AHSAO	Afghan's Health and Social Assistance Organization
ANLF	Jebbe-ye Nedjat-e Melli-ye Afghanistan (Sigbatullah Mujaddidi)
AVICEN	Afghan Vaccination and Immunization Centre
BCG	Vaccine against tuberculosis (bacillus Calmette-Guerin)
CMC	Coordination of Medical Committees
EPI	Expanded Programme on Immunization
FM	Freedom Medicine
GAF	German Afghan Foundation
HIA	Hezb-e-Islami (Gulbuddin Hekmatyar)
HIA	Hezb-e-Islami (Younis Khales)
Harakat	Harakat-e-Enqilab-e Islami (Mohammed Nabi Mohammadi)
ICRC	International Committee of Red Cross
IFAD	International Fund for Agricultural Development
IMC	International Medical Corps
IPD	In-Patient Department, hospital
Ittehad	Ittehad-e-Islami Barai Azad-ye Afghanistan (Abdul Rasul Sayyaf)
JIA	Jamiat-e-Islami (Burhannudin Rabbani)
JOG	Joint Operations Graphic, map
KRCS	Kuwait Red Crescent Society
Mahaz-e-Milli	Mahaz-e-Milli-ye Islami (Sayyid Ahmed Gailani)
MCI	Mercy Corps International
M.D.	Medical Doctor
MDM	Medecins du Monde
MSF	Medecins sans Frontieres
MSH	Management Sciences for Health
MTA	Medical Training for Afghans
N	Number
NCA	the Norweigan Committee for Afghanistan
NIFA	Mahaz-e-Milli
OPD	Out-Patient Department
RN	Registered Nurse
SCA	Swedish Committee for Afghanistan
SRCS	Saudi Red Crescent Society
TB	Tuberculosis
UAAR	Union Aid for Afghan Refugees
UAC	Upper Arm Circumference
UMCAMD	United Medical Centre of Afghan Mujahid Doctors
UNICEF	United Nations Children's Fund

11.3 PRICE SURVEY

Below is listed prices of commodities and labour costs that give an idea of prices in September 1989. Taloqan has a city bazaar with a substantial sale of imported goods as well as local handicrafts. The bazaars in Farkhar and Khanaqa are dependant on the trade route to Taloqan. The Khanabad bazaar is similar to Taloqan, but smaller. All these bazaars have a substantial inflow of Russian or Afghan government produced agricultural input-products. In Nahrin, Andarab and Panjshir the proximity to Kabul is visible in the bazaar. In Panjshir the food prices are high because of transportation costs.

	Warsaj	Farkhar	Taloqan	Khanabad
Wheat/Seer	450	500	500	400
Rice/Seer	-	1500	1300	1500
Diesel/Liter	200	150	100	90
Unskilled Labor/Day	300	600	550	800 *)
Skilled Labor/Day	800	1500	2000	2200
Urea/bag	1400	2000	1500	1500
Kerosene/liter	-	70	50	50
D.A.P/bag	1200	2000	1800	3000
Sugar/kg	-	340	300	300
Ghee/Seer	3500	3500	3000	3000
Milk Powder/Can	-	550	500	500
One Draft Oxen	60000	180000	150000	100000
Black Tea/kg	-	2000	1700	1600
Sheep Meat/kg	1000	375	440	560
One Chicken	-	2000	1000	1500
A Bar of Soap	100	120	120	110
Tractor/hour	-	-	-	1900

*) seasonal variation 600-1200

	Nahrin	Andarab	Panjshir
Wheat/Seer	675	500	900
Rice/seer	1300	-	2000
Diesel/Liter	100	100	200
Unskilled Labor/Day	600	1000*	500
Skilled Labor/Day	1500	2000	1500
Urea/bag	1800	1200	2000
Kerosene/liter	130	-	not available
D.A.P/bag	3000	3000	3500
Sugar/kg	1000	-	700
Ghee/Seer	3100	3500	3400
Milk Powder/can	600	-	600
One Draft Oxen	110000	100000	150000
One Chicken	1200	-	1500
Sheep Meat/kg	500	575	600
Black Tea/kg	1700	-	1600
A Bar of Soap	60	120	130
Tractor/hour	1750	10% **	-

*) harvest time price?
**) ten per cent of harvest yield

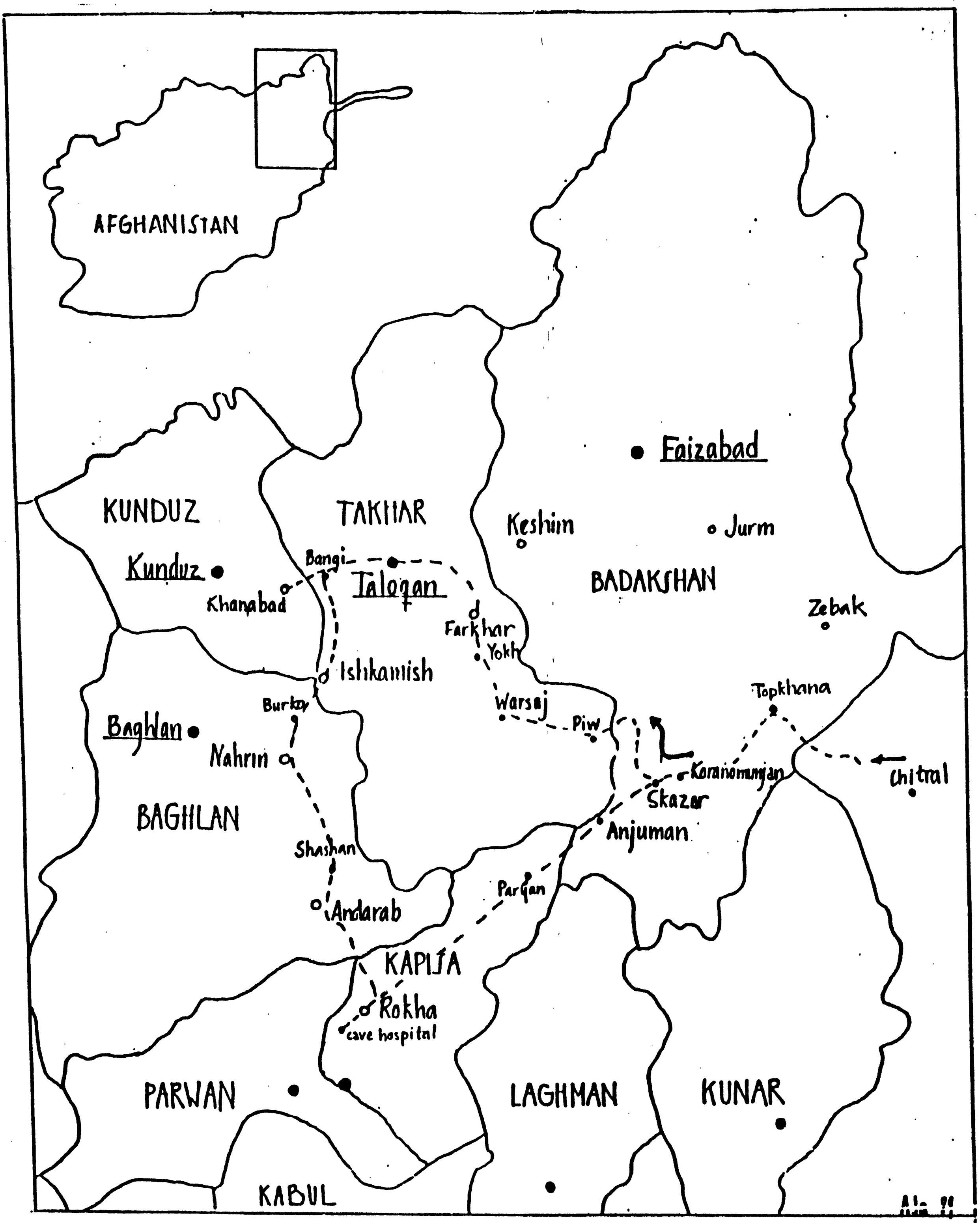
PURCHASING POWER

Below is a summary of local variations in the number of hours an unskilled labourer must work in order to buy a seer (7 kg) of wheat (8 hours day/daily wage, local wheat price).

the Panjshir: 14 hours
Warsaj: 12 hours
Nahrin: 9 hours
Farkhar: 7 hours

Taloqan: 7 hours
Andarab: 4 hours
Khanabad: 4 hours

1. MAP OF NORTH-EAST AFGHANISTAN



---- the trip

11.4 TABLE OF CONTENTS OF DETAILED REPORT

2. INTRODUCTION

Background

Coordination of Medical Committees (CMC), was set up in 1986 to coordinate the activities of Non-Governmental Organizations (NGO) working with health in Afghanistan.

Since 1988 one of CMC's major tasks has been to monitor the member groups' activities in Afghanistan. Previous CMC monitors have visited the North-East, the East-Central and the Kandahar regions. Reports of these missions are available at the CMC office.

Objectives

The objectives for this monitoring trip were to:

1. Get an overall view of the health care system, especially in terms of how clinics cooperate with, and complement each other.

2. Identify locations where female programmes could be initiated.

3. Study the prevalence of goiter and malnutrition.

4. Get an impression of the area in terms of agriculture, education and infrastructure.

5. Verify the presence of clinics and health workers.

CMC Personnel

1. Monitor: Annika Janson, Medical Doctor, Swedish national. Before the journey she had been working in Peshawar for nine months, as a coordinator of Mother and Child Health care among refugees at Afghan's Health and Social Assistance Organization (AHSAO).
   Languages: Swedish, English, German and Farsi.

2. Translator: Sayed Habib Shah from Ningahar, Afghanistan. He is Assistant Director of CMC. Education: Agricultural College (Afghanistan) and Public Administration (USA).
   Languages: Farsi, Pashtu, English and Urdu.

Methodology

The CMC monitoring questionnaire was used for clinic monitoring. The questionnaire has three parts:

1. Interview of Health Worker
2. Observation of Facility and Health Worker
3. Interview on Resettlement Issues

Separate studies were done for the goiter and malnutrition survey work.

Geographical Area

This monitoring mission was originally planned for Badakshan province. Due to many reasons (please see section 4 "The Journey"), portions of Takhar, Kunduz, Baghlan and Kapisa provinces were surveyed.

Badakshan and the North-East was monitored by the first CMC monitoring team one year ago. The monitors came to the conclusion that the time of year was unsuitable, because few of the health workers were present at their locations.

Other reasons for repeating the mission to North-East Afghanistan were that the health care picture most likely had changed with the liberation of some major cities and their hospitals, the possibility of carrying out prevalence studies, and the use of a female monitor to check the possibilities for female programmes.

Methods of Transportation

We went into the area on horseback, but could do a lot of travelling by rented cars and military vehicles in the area. When roads were bad or unsafe, we rode on rented horses or simply walked.(For details on roads please see section 4 "A Narrative of The Journey", or the section "Infrastructure" in the Detailed Report.)

Constraints in Data Collection

Prior to the journey several CMC board members expressed the attitude that they were not so interested in the performance of the individual health workers, but more in overall aspects of the health care situation. A need to see how the healthworkers divided the work between them, and managed their clinic, was also expressed. Consequently, there are no reports on the performance of individual health workers, but rather the report concentrates on other information.

Due to the change in route, I had no detailed information on health clinics in the area I visited. I ask the readers to forgive the focus on larger clinics and hospitals, which was the result of their greater importance as well as of my lack of information of the smaller clinics' location.

Because a second CMC physician monitor became seriously ill prior to departure, a malaria prevalence study was not conducted.

Reports

Apart from this General Report, there is a Detailed Report with information on each clinic visited. A table of contents of the Detailed Report is included in this report as appendix 4.

A Picture Report with pictures from the trip, clinics, staff and commanders has been produced in two copies. One has been given to UNICEF, and the other remains in the CMC-office.

Annika Janson
Peshawar

October 30th, 1989

NOTE: The contents of the reports of CMC Monitoring Mission # 5 to North-East Afghanistan include thoughts and opinions of a CMC contracted medical monitor which may or may not reflect official CMC health policy. - Editor

3. SUMMARY OF INFORMATION AND RECOMMENDATIONS

Administrative Organization

North-East Afghanistan is an area primarily under the control of the civil administration of Shura-e-Nizar. This provides the stability necessary for development aid, and sets the foundation for new tasks to be addressed by the NGOs.

The North-East is liberated and rather peaceful, although the conflict between HIA and JIA had a negative influence on our trip. There are roads and vehicles. Patients can travel. The need for first-aiders treating war wounds is diminishing and the need of hospitals with skilled staff able to provide surgical services, medical investigations, laboratory and X-ray services, is increasing. Health NGOs must increase their contribution to the ordinary operating expenditures of hospitals. The establishment of a referral network is also extremely important.

In my opinion the Shura-e-Nizar, as the locally accepted administrative body in the North-East, should be given a greater influence over the allocation of aid money in the area. A strong civilian leadership, such as the Shura-e-Nizar, is a prerequisite for successful long-term development aid. With the previous approach, emergency aid in a war situation was distributed to individual commanders whose duty it was to distribute it to recipients subject to little selection and no technical considerations. The Shura-e-Nizar is the accepted structure for building a civilian "government" that can make plans, set priorities and concentrate reconstruction and development efforts more efficiently. There is no legitimate reason why NGOs shifting from emergency relief to development relief should choose not to cooperate with this existing civilian structure.

Working with the Shura-e-Nizar will, consequently, decrease the influence of individual NGOs in making programme decisions in the utilization of their resources. It is important to identify the persons within the Shura-e-Nizar that can become good counterparts.

Surgery

In the area visited there are six hospitals with facilities for surgery; Yokh, Taloqan, Khanabad (soon), Khel Ab (not visited), Rokha, and the new cave hospital of the Panjshir valley. Surgery, other than wound care, should be discouraged at the Farkhar clinic and probably also at the Nahrin clinic. The facilities are not satisfactory and in neither clinic is there a graduate doctor.

I identified four or five surgeons able to do laparotomy. They work in the two hospitals in the Panjshir valley, and in Taloqan. No surgeon is performing Caesarean sections. The government hospitals of Kunduz city, Faizabad, Charikar and Baghlan city can provide assistance for some categories of patients. The MSF hospital in western Badakshan (Teshkan)

provides minor surgery. The hospital in Keshim, Badakshan, is said to be poorly staffed and equipped.

The need for planning a programme for evacuation and surgical care of Kabul wounded to the North, once the fighting intensifies, was addressed by Dr Walid in Rokha.

Present Referral Links

The existing hospitals can be classified as war-hospitals treating mostly wounded adult males. The main reason for referral within the area is the need for abdominal surgery. The hospital in Taloqan is not yet the main referral center, but the plans of the Shura-e-Nizar are that it shall become the prime hospital of the Northeastern Zone. Rokha in the Central Zone, and Khel Ab and Yokh in the Northeastern Zone are currently the best working clinics in terms of surgery. For difficult medical cases there is no good system of referral. Patients are sent to Pakistan (5 days from Yokh and Rokha) for prostheses, psychiatric illnesses, eye diseases, tuberculosis and paraplegia.

Females

Female staff (six) work in Taloqan hospital and a female nurse is sometimes helping at the Nahrin clinic. In Taloqan and Nahrin it seems possible to start female training programmes training traditional birth attendants and maybe nurses, as well as outreach programmes. The high prevalence of malnutrition in children is also a strong argument for starting basic teaching directly to mothers, in association with their clinic visits.

Female patients can generally be examined by male health workers. A stethoscope can be used, often outside the clothes, and stomachs are examined through the clothing. The more serious the woman's illness, the more examination seems possible. Gynecological examinations, however, are never performed by male medical staff, nor by graduate doctors. The female staff in Taloqan and Nahrin make gyne-exams and assist at deliveries.

Female wards are present in a clinic associated with the hospital in Rokha, and in Taloqan hospital. There will probably be a female ward in Khanabad hospital.

Tuberculosis

The organization of the clinics and the population is now so stable that treatment of tuberculosis patients could be started in small scale in the Panjshir, and maybe in Taloqan. In both these places X-ray and laboratory facilities must be improved. The morbidity in tuberculosis appears to be high in North-East Afghanistan.

Vaccination

Children are presently being vaccinated (according to the Expanded Programme on Immunization, EPI) in the Panjshir and Nahrin by AVICEN-trained vaccinators. At least in the Panjshir, only a few women have been vaccinated. In Taloqan and Khanabad it should be possible to start vaccinations, and in Yokh and the upper Farkhar valley also, though this area is less densely populated.

A possible location of a freeze/cold spot is the power plant of Khanabad.

Iodine Distribution

In Northern Afghanistan goitre seems to be endemic (1). Previous studies by MSF in Badakshan (2) show a 43 per cent (N = 2823) prevalence of goiter. I carried out a small study (N = 142) in three different places and found goiter in four of ten (40 %) women between ages 15 and 45. This indicates a prevalence similar to that in Badakshan. No iodized salt was seen in the bazaars. A programme for distribution of iodized oil, or iodized salt, should be considered.

Malnutrition in Children

Upper Arm Circumference (UAC) was used to check the nutritional status of children between one and five years of age. MSF has recorded a prevalence of malnutrition in Badakshan of 35 - 45 per cent (3). In my small study (N = 114) about half the children could be classified as malnourished. Malnutrition seems to be associated with infectious diseases (measles), war actions and lack of knowledge, and to a lesser extent to actual lack of food.

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1. Thanh Nguyen Duc, AVICEN: Endemic Goitre Survey
2. Therese Gandon, MSF France: Enquete sur l'Incidence du Goitre Endemique et du Tetanos Neonatal au Badakhshan.
3. Frederic Tassilly, MSF France: Vaccination Anti- Rougeoleuse, Enquete Nutritionnelle.

GENERAL REPORT

CMC MONITORING MISSION #5

TAKHAR, KUNDUZ, BAGHLAN, AND KAPISA
PROVINCES